DPH Date Rec'd (stamp)

NURSING COMPLAINT FORM

DEPARTMENT OF PUBLIC HEALTH

DIVISION OF HEALTH PROFESSIONS LICENSURE
OFFICE OF PUBLIC PROTECTION
TEL (617) 973-0865 FAX (617) 973-0985 TTY (617) 973-0895
http://www.mass.gov/dph/boards/

DPH USE ONLY:
Entered into Database (date) _____/_ _____/_____ Docket # _____ - _____ - _____ Initials _____

Please complete this form as fully as possible. Please TYPE or WRITE LEGIBLY in ink.

COMPLAINANT

☐Mr.
☐Mrs.
☐Ms. _____ _____ _____ _____
Your Last Name | Your First Name | Patient's Name (if different) | Patient's Age

Your Business Name: _____
(if applicable)
Business Address: _____ _____ _____
Street | City | Zip

Complainant Address: _____ _____ _____
Street | City | Zip

Patient's Address (if different): _____ _____ _____
Street | City | Zip

Your Primary Phone number: ( ) | Your Secondary Phone number : ( ) | Your Email:

LICENSEE

☐ REGISTERED NURSE ☐ LICENSED PRACTICAL NURSE ☐ ADVANCED PRACTICE NURSE

_____ _____ _____
Licensee's Last Name | Licensee's First Name | Lic # (if known)

Business Name:_____ Phone #:_____

Business Address: _____ _____ _____
Street | City | Zip

COMPLAINT DESCRIPTION

DATE(S) OF INCIDENT(S): _____

DETAILS OF COMPLAINT: Clearly describe the incident(s) leading up to your complaint. If applicable, **attach copies** of documents such as: witness statements, medical records, copies of prescriptions, photographs etc. that support your statements. PLEASE SEND COPIES; originals will not be returned to you. Attach extra paper as needed to complete this section.

_____
_____
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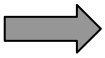
Continue on next page if needed 

NURSING CON'T

Details of Complaint continued

_____

_____

_____

_____

COMPLAINT DETAILS

Have you discussed this matter with the licensee, the licensee's office or facility? ☐ yes ☐ no

If yes, name and phone number of person contacted: _____

Date of contact: _____ How was contact made? (phone, e-mail, letter, in person) _____

Result of contact: _____

_____

_____

If there are **witnesses** to your complaint, please provide witness name(s) and telephone number(s) (if applicable)

_____

Have you filed this complaint with any other state or federal agencies? ☐ yes ☐ no If yes, explain_____

_____

If resolution of this complaint requires it, **are you willing to testify** in person regarding this matter at a formal hearing?
☐ Yes, I am willing. ☐ No, I am not willing.

AUTHORIZATION FOR RELEASE OF RECORDS AND REFERRAL OF COMPLAINT

My signature on this form, or photocopy thereof, authorizes the Department of Public Health Office of Public Protection to: (1) receive copies of all my medical, dental, and mental health records relating to my complaint, and (2) to refer my complaint to other law enforcement authorities for appropriate action.

I understand that all complaints are investigated to determine their factual basis.
The act of filing a complaint and its receipt and/or investigation by DPH does not mean that disciplinary action will be taken against the licensee.

I hereby declare that I am at least 18 years old and affirm under penalties of perjury that the information provided in connection with the foregoing complaint is true and correct to the best of my knowledge, information and belief.

_____ _____

Signature of **Date**

☐ **Patient or**
☐ **Legal Representative, or**
(attach documentation)
☐ **Complainant**

Mail this form to:
Department of Public Health
DHPL Office of Public Protection
239 Causeway Street, 4th Floor
Boston, MA 02114